PRINTED: 05/01/2008 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
			8. WIN		·	<del></del>		
WAAF		09G173	10.00			···	04/	04/2008
ST JOHN	ROVIDER OR SUPPLIER			4815	raddress, city, sta <b>Chesapeake s</b> tre <b>Shington, dc 20</b>	EET, NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECT VE ACTION SHOULD TO THE APPRICIENCY)	ULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	ទេ	wo	00 1			··	
W 153	2, 2008 through Ap initiated using the fir random sample of the random sample of the resident population disabilities. Client of facility on October 2 Client #3's admission conducted (admitter 2007). The findings observations, intervative home and at on review of client and including incident resident	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other noe with State law through	W 1	53			2008 MAY 15 P 3: 08	BEPARTHENT OF HEALTH HEALTH REGULATION
	Based on interview, review of client reco ensure that an alleg verbal abuse was re							
ABORATOR	On April 2, 2008, th (RTL, aka House M the entrance confer	e Residential Team Leader lanager) was interviewed for ence, beginning at 9:00 AM. per/supplier representatives sign	NATURE	A	<u>rogram</u>	Direc	la contraction	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6SWZ11

Facility ID; 09G173

	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  (X3) DATE SURV COMPLETED  A. BUILDING						
		09G173	B. WIN	G		04/04	/2008
NAME OF P	ROVIDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 815 CHESAPEAKE STREET, NW VASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ŲLD BĒ	(X5) COMPLETION DATE
W 153	At approximately 9 incident in which C program one morn program staff that how residential stain tears when she stelephone. The RT been reported and asked about the ouperson is no longer Management Coor staff on how to spen proper tone of voice the incident report were available for iday.]	ige 1 30 AM, she described an lient #1 arrived at her day ing in tears. She told day she was very upset" about ff talked to her. The client was spoke with the RTL by "L said that the incident had investigated promptly. When atcome, the RTL stated "that in here" and the Incident dinator (IMC) had in-serviced tak with the clients using a e and respect. [Note: Neither s) or the investigation report review in the facility on that	W 1		All staff were in-serviced on "Sensitivy" by the Incident Management Coordinator, and an investigation was completed as well. However, the investigation was not filed in the facility book of standards and compliance.  Refer to attachment #1 a & b.  In the future, the incident management coordinator, and the facility management team will ensure that the records are filed in the books, and availlable upon request.		
	facility, beginning a a staff person telep morning to inform "upset, crying." St something that ups The IMC came to t client. It was unce incident had occur that the incident had during an outing to that staff had said that effect.	at 5:04 PM. He described how bhoned him on a Friday him that Client #1 had been aff had allegedly said set her on the night before, the facility and interviewed the ear as to when or where the red. There was some evidence ad occurred the night before, a nightclub. Client #1 alleged "don't be lazy" or something to	. •		The Psycholigist is still in the process updating individual #1 Psychological to include Sensitivy issues.	assessment,	5-19-08
	reportedly occurred by telephone with a in-service training then talked about a driving Client #1 in morning, the second	cribed another incident that d the following week. He spoke staff in the home about on sensitivity issues. The staff the training while they were the facility van. It was on that and incident, that the client gram upset that staff had talked					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUİLDIN	PLE CONSTRUCTION G	(X3) DATE SUI COMPLET	
		09G173	B. WING _		04/04	/2008
NAME OF F	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 815 CHESAPEAKE STREET, NW VASHINGTON, DC 20016		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 153	about her while the On April 3, 2008, a the facility and pres dated February 6, 2 and the correspond February 20, 2008, documents revealed  1. Although the invertee first time the cli February 1, 2008, staff prepared an in accordance with far incident report for 6 February 6, 2008, business days) after allegation.  2. There was no of facility's administrated client #1's February 3. Pre-survey revision followed by an ons documents in the first the State ager February 1, 2008 of 4. There was no of facility's administrated client #1's second 2008.  5. Pre-survey revision followed by an ons documents in the first followed by an ons documents followed by an ons do	y were all in the van.  3:28 PM, the IMC arrived in sented two (2) incident reports, 2008 and February 14, 2008, fing investigation report, dated Immediate review of the 3d the following:  yestigation report indicated that ent was in tears was on Friday, there was no evidence that incident report that day, in cility Policy Number 170. The shat complaint was dated five (5) calendar days (3 are the client first made her  ocumented evidence that the stor was notified immediately of my 1, 2008 allegation.  ew of State agency records ite review of relevant facility failed to show evidence mcy was notified of the client's complaint.  Incommented evidence that the stor was notified immediately of complaint, on February 14,  ew of State agency records site review of relevant facility failed to show evidence complaint, on February 14,	W 153	All staff were retrained on the incide reporting. Refer to attachment # 2  In the future, the facility will ensure incidents are reported on a timely mas stipulated in the incident manager. The facility's administrator will be immed notified of all of the incidents that occur. In the future the house management will ensure that the administrator is notified the incidents. The facility's administrator initial the incident report as indication of aknowledgment.  All occurring incidents will be reported to Agency. In the future, the facility will ensure that incidents are documented, and reported the State Agency.  Refer to W 153 (2) P. 3  Refer to W 153 (3) P. 3	that all anner ment policy. liately in the home. I on all of will the State	-11-08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SU COMPLET	
	•	09G173	B. WIN	IG	· · · · · · · · · · · · · · · · · · ·	04/04	/2008
NAME OF P	ROVIDER OR SUPPLIER			48	EET ADDRESS, CITY, STATE, ZIP CODE 315 CHESAPEAKE STREET, NW /ASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 156	CLIENTS  The results of all in to the administrator or to other officials within five working  This STANDARD is Based on interview failed to ensure that to the administrator within five working	vestigations must be reported or or designated representative in accordance with State law days of the incident.  is not met as evidenced by: and record review, the facility at investigations were reported or or designated representative days of the incident, for one of the sample. (Client #1)	W *	156			
W 159	with the Residentia Incident Manageme (2) incidents in which allegations that state about her in a disressincidents had occul February 14, 2008, report and staff with February 6, 2008, into one investigating February 20, 2008. Client #1's February administrator in account and the facility's possible 483,430(a) QUALITI RETARDATION Pile Each client's active	63. On April 2, 2008, interviews of Team Leader and the ent Coordinator revealed two ch Client #1 cried and made of that spoken with and/or espectful manner. The red on February 1 and The earliest dated incident ness statements were dated Both incidents were combined we report document, dated There was no evidence that by 1, 2008 allegation of staff investigated within five working lts reported to the cordance with the regulation of staff investigated.	W	159	All staff were in-serviced on "Sensitiv Incident Management Coordinator, a investigation was completed as well. the investigation was not filed in the of standards and compliance.  Refer to attachment #1 a & b.  In the future, the incident managem coordinator, and the facility manage will ensure that the records are filed books, and available upon request.	and an However, facility book ent ment team	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G173	B, WI	IG _		04/04	4/2008
NAME OF P	ROVIDER OR SUPPLIER		•	4	EET ADDRESS, CITY, STATE, ZIP CODE 816 CHESAPEAKE STREET, NW VASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO DEFICIENCE		CTION SHOULD BE O THE APPROPRIATE	
W 159		ge 4 ardation professional. s not met as evidenced by:	W	/ 159			
·	Based on observati review, the Qualifie Professional (QMR monitor programs a four clients residing #3)	on, interview and record d Mental Retardation P) failed to coordinate and and services, for two of the in the facility. (Clients #2 and					
	ensure the coordinate	a: /331.2. The QMRP failed to ation of services between a r room (ER) and the facility, as					·
	of incident reports in Client #2 went to the staff observed some Diagnostic performance that review hernia." An incident November 15, 2007 Management Coord	eginning at 10:31 AM, review n the facility revealed that e ER on July 8, 2007 after ething different with her chest ed at the hospital included a ealed a "probable hiatal it investigation report, dated and prepared by the incident dinator, following another ER ral diagnoses, including a			Once the individual is discharged from ER/hospital, the house manager informedical team that usually reports to house to address the issues, concern	orms the the ns, and	
	On April 3, 2008, beginning at 2:07 PM, review of Client #2's medical records failed to show evidence that the medical team had addressed the hospital's findings to date. On April 4, 2008, at 3:45 PM, the RN who had prepared a January 31, 2008 Nursing Assessment was asked about Client #2's reported hiatal hernia. He examined the hospital documents from July 2007 and acknowledged that he was previously unaware of				follow up on the findings and recommend of the future, the facility medical teal ensure that all the hospital findings are addressed on a timely manner.	am will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		09G173	B. WING		04/04	1/2008
NAME OF P	ROVIDER OR SUPPLIER		4	LEET ADDRESS, CITY, STATE, ZIP CODE B16 CHESAPEAKE STREET, NW VASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
W 159	Director of Nursin facility at the time findings.  2. The QMRP fai behavioral data w follows:  On April 2, 2008, of her bedroom are on her way to the to a floor lamp in and placed her no shade, before comment later, shouse to a bouque the center of the tamber of tamber of the tamber of tamber of the tamber of the tamber of the tamber of the tamber of	ings. He showed it to the g, who was present in the g, who was unaware of the led to ensure that baseline as collected for Client #3, as at 7:32 AM, Client #3 walked out and came through the living room dining room. She stopped next the living room, leaned forward use (briefly) against the lamp attinuing to the dining room. A se bent over and touched her to fartificial flowers that were in able. At approximately 8:15 I this behavior, when she placed gainst the back of her dining to the dining the conference, at 9:10 AM that idential Team Leader (RTL, aka indicated that the client had asing behavior since she was clitty in June 2007. The client is on facility walls, leaving alls. This reportedly had been in December 2007, when Client is a sinus infection. The propriate recommendations.	W 159	Staff did collect data to baseline income behaviors of concerns for 30 days aby the Psychologist; however, based data collection, there was no suffithe intensity of this behavior, and consequently to draft a BSP; also it was diagnosed with Sinus.  Since the behavior has reoccured, is updating individual #3 baseline of concerns.  In the future, the facility will ensure behaviors are address as they occur	as recommended on the icient data that individual #3 the Psychologi for her behavior that all	t indicated
		3 was not in the sample, a f her admission documentation			·	

		(X3) DATE SU COMPLE					
		09G173	B. WING	G	<del></del>	04/04	1/2008
NAME OF P	ROVIDER OR SUPPLIER			48	EET ADDRESS, CITY, STATE, ZIP CODE 15 CHESAPEAKE STREET, NW ASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 159	was conducted bed to the facility within On April 4, 2008, be Client #3's record of admitted on June 2 assessed her short Psychological Evaluate psychologist respective data, to be August 2007. Furth showed no evidence had reviewed Cliert July 2007. 483.450(a)(1)(i) Constitution of the psychologist respective data incompassed in the data since had reviewed Cliert July 2007. 483.450(a)(1)(i) Constitution of the policies and growth, development of the psychologist and growth, development data since had reviewed Cliert and growth, development data since had reviewed to the psychologist and growth, development data since had reviewed the psychologist and growth, development data and growth data an	cause she had been admitted the past twelve (12) months. Deginning at 2:40 PM, review of confirmed that she was 29, 2007. A psychologist the thereafter. In the fluation, dated July 30, 2007, recommended collecting are reviewed at the end of the review of the record ce that staff had collected at then or that the psychologist at #3's behavioral needs since ONDUCT TOWARD CLIENT of procedures must promote the ent and independence of the is not met as evidenced by: tion and record review, facility istently promote client one of the two clients in the	W 1		Staff did collect data to baseline individual #3 behaviors of concerns for 30 days as recommende by the Psychologist; however, based on the data collection, there was no sufficient data that indicated the intensity of this behavior, and consequently to draft a BSP; also individual #3 was diagnosed with Sinus.  Since the behavior has reoccured, the Psychologis is updating individual #3 baseline for her behavior		t
	seated in a wheeld needed to use the staff pushed the cl dining room to the participate in proposes was not observed do so. During the	es:  at 8:29 AM, Client #1, who was chair, informed staff that she restroom. A direct support lient's wheelchair from the restroom. The client did not elling her wheelchair and staff offering her encouragement to entrance conference that kimately 9:15 AM, the		1	All staff were inserviced on the active with emphasis of promoting independ Refer to attachment #3 In the future the facility management that staff assist the individual, and en activities that promote independence.	lence. t will ensure courage the	4-29-08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		09G173	B. WING _		04/0	4/2008
NAME OF P	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP COD 815 CHESAPEAKE STREET, NW VASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 268	required assistant her wheelchair to otherwise, she was wheelchair.  Client #1 was obsthat day. At 12:47 propelling her whe independently, in treatment room to Client #1 propelle independently. The remainder of the were observed purithe of the were observed purithe asking her on April 3, 2008 at Occupational The November 17,1 2 independent in the relied on staff assistant assessment findir Physical Therapy 26, 2007 and Mar 483.460(c) NURS The facility must provide the services in according to the services in according to the services in according to the whole when the services in according to the services in according to the whole when the services in according to the whole when the services in according to the whole whole who the services in according to the whole who the services in according to the whole who the services in according to the whole whole whole whole whole whole who the services in according to the whole w	Leader stated that Client #1 ce with transfering in and out of the commode and to her bed; is independent with her  erved at her day program later PM, she was observed selchair manually, and the hallway from her day the cafeteria. At 1:15 PM, d her chair out of the lunchroom ne next morning, and throughout the survey, staff in the home shing the client's wheelchair r first if she wanted assistance.  at 9:20 AM, review of Client #1's rapy assessment, dated 007 revealed that she was a use of her wheelchair but istance with transfers. Similar ngs were documented in Assessments dated November ch 21, 2008.	W 268	All staff were inserviced on the a with emphasis of promoting inderence to attachment #3  In the future the facility manager that staff assist the individual, an activities that promote independence with emphasis of promoting inderence to attachment #3  In the future the facility manager that staff assist the individual, an activities that promote independence indepe	ependence.  ment will ensure id encourage the ence.  ctive treatment ependence.  ment will ensure id encourage the	4-29-08
	The findings inclu	de:				

#### PRINTED: 05/01/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING\_ 09G173 04/04/2008

NAME OF PROVIDER OR SUPPLIER

ST JOHN	SUMMARY STATEMENT OF DEFICIENCIES		4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016 PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
W 331	Continued From page 8	W 331			
	1. On April 2, 2008, the Residential Team Leader (RTL, aka House Manager) was interviewed for the entrance conference, beginning at 9:00 AM. At approximately 9:15 AM, she indicated that Client #1 required assistance with transferring in and out of her wheelchair to the commode and to her bed; otherwise, she was independent with her wheelchair. Beginning at 10:31 AM, review of incident reports in the facility revealed that on January 28, 2008, at 8:15 AM, direct support staff working with Client #1 discovered a blister on the top of her right foot. The client reportedly told the staff that her foot had slid "underneath the heater on the floor" while transferring from her wheelchair onto the commode earlier that day.  a. On April 3, 2008, beginning at 9:17 AM, Client #1's Occupational Therapy assessment, dated November 17, 2007, Physical Therapy assessments, dated November 26, 2007 and March 21, 2008, and annual Individual Support Plan, dated November 29, 2007, verified that the client required staff assistance while transferring from her wheelchair to the commode. The March 21, 2008 PT assessment recommended use of a gait belt for the staff to "assist with transfers." [Note: The gait belt was available for use during the survey.] The PT also stated the client "should be supervised closely for all transfers." However, further review of these and the client's other health and habilitation records failed to show evidence of instructions or a protocol that specified how staff were to assist during the transfer and/or how to prevent falls.  b. On April 4, 2008, at 2:56 PM, review of Client #1's Health Management Care Plan (HMCP), dated March 13, 2007, revealed that it did not		All staff were inserviced on the individual monitoring, and on the use and importance of the adaptive adaptive equipment ( gait belt)  Refer to attachment # 4  In the future, the facility will ensure that the staff use the adaptive as recommended by the Physical Therapist.	4-29-08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLANC	FCORRECTION		A. BUILDIN	G	·	
		09G173	B. WING _		04/04	4/2008
NAME OF P	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP ( 815 CHESAPEAKE STREET, NW VASHINGTON, DC 20016		· .
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 331	transfers, nor did it leg braces (for ede was no evidence to updated the client	age 9 of staff assistance needed for the address the use of her lower the agents of the staff assistance needed for the address the use of her lower than 5 and 12 and 14 and 15	W 331	Individual #1 Health Managem revised, and included the use obraces, and fall precautions.  In the future, the facility nursing that the HMCP is updated on a and included all of the pertaining	of the lower leg ng team will ensure timely manner,	4-15-08
	records on April 4, revealed no evided training for staff or and/or safety prec techniques. The r in-service training	that review of staff training 2008, beginning at 4:00 PM, nce that the PT had provided in the use of the client's gait belt autions, lifting and transfer most recent documented staff on lifting and transfer sen provided by an LPN in ember 2006.		The PT did inservice the staff of Refer to attachment #4 In the future, the facility will eare inserviced on the safety prongoing basis.	ensure that staff	4-24-08
	said there had been bathroom at the time evidence that the in accordance with	r noted that although the RTL en staff assisting Client #1 in the me of the burn, there was no incident had been investigated, in facility policies.				
	review of incident that Client #2 wen on July 8, 2007 at different with her of the hospital including probably hiatal hospitalization, or She was not eating movement. The chospital ER via 97 papers dated Novempaction and an	reports in the facility revealed at to the emergency room (ER) ter staff observed something chest. Diagnostic performed at led a chest x-ray that revealed a crinia." On November 10, 2007, I home from another ally to show signs of discomfort. In an another was taken that day to a learn that the discharge rember 13, 2007 reflected fecal at stricture. The incident at the discharge reflected November 15, 2007		Once the individual is discharge ER/hospital the house manage medical team that usually repellures to address the issues, follow up on the findings and In the future, the facility medensure that all the hospital finare addressed on a timely management.	er informs the orts to the concerns, and recommendations. lical team will dings are	·

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
	·	09G173	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	000173		STREET ADDRESS, CITY, STATE, ZIP COI		4/2008
ST JOHN				4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 331	and prepared by the Coordinator, reflect a "large hiatal herni On April 3, 2008, be Client #2's medical evidence that the managed. The clie Evaluation, dated Fereflect a diagnosis of client's annual Nurs January 31, 2008.	e Incident Management ed those diagnoses as well as	W 3	Individual #1 Health Managemer revised, and includes all of the di In the future, the facility nursing that the HMCP is updated on a ti and included all of the pertaining	agnoses team will ensure mely manner,	4-15-08
	prepared the Januar Assessment was as reported hiatal herrodocuments from Juthat he was previous findings. He showed who was present in too was unaware of	a 3:45 PM, the RN who had ary 31, 2008 Nursing sked about Client #2's area. He examined the hospital by 2007 and acknowledged asly unaware of the hospital's ed it to the Director of Nursing, the facility at the time. She is the findings. She indicated would be shared with the sian.		Once the individual is discharged ER/hospital the house manager medical team that usually report house to address the issues, corfollow up on the findings and recurrent in the future, the facility medical ensure that all the hospital finding are addressed on a timely manning the supplemental force.	informs the s to the neerns, and commendations.  I team will gs are	
W 368	determined what, if plan or further diago Client #2's reported 483.460(k)(1) DRU The system for drug	G ADMINISTRATION g administration must assure dministered in compliance with	VV 3(	68		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	-	09G173	B. WIN	G		04/0	4/2008
NAME OF PI	ROVIDER OR SUPPLIER			4815	T ADDRESS, CITY, STATE, ZIP COL CHESAPEAKE STREET, NW SHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 368	Continued From pa	ge 11	W 3	68 1			
W 369	Based on observativerification, the fact were administered orders, for one of the facility. (Client #4)  The finding include:  Cross-refer to W36 #4 was observed mat various times duafternoon. It was laphysician's orders factorially for the syrup in accordance 483.460(k)(2) DRU  The system for drugthat all drugs, included al	9.4. On April 2, 2008, Client taking a deep, gurgling cough ring the morning and after determined that she had for "Bromatane DX cough th, 4 times daily as needed for #4 did not receive cough e with physician's orders. G ADMINISTRATION g administration must assure ding those that are are administered without error. It is not met as evidenced by: son, interview and record ailed to ensure that administered as prescribed, for ents residing in the facility. #4)  e: sation administration pass was 1, 2008, beginning at 7:13 AM.	<b>W</b> 3	69			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		•	A. BUILDI		
		09G173	B. WING_		04/04/2008
NAME OF P	ROVIDER OR SUPPLIER I		- 1	REET ADDRESS, CITY, STATE, ZIP CODE 1815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORREC	CTION (VE)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
W 369	(TME) squeezed 1 into Client #1's left however, did not to appropriate mome the nasal spray be client any instruction. TME was not observe that Client	age 12 a trained medication employee spray of Flonase nasal spray and right nostrils. The client, ake in a breath at the ents when the nurse squeezed attle. The TME did not offer the lons during this process. The erved using effective means to #1 received her prescribed ordance with the physician's	W 369	All of the facility TMEs were trained administration refer to attachment #5  In the future, the facility will ensure medications are administrated as prothe physician.	4-29-08 that all of
	Dilantin into a med of a file cabinet. T receive 4 ml of liqu TME reached for t client, who was se her wheelchair, sh to administer the r medicine cup reve of liquid poured.	a TME poured Client #2's liquid dicine cup and placed it on top the client's orders were to aid, or 100 mg Dilantin. As the he medicine cup to take to the ated at the breakfast table in the indicated that she was about medication. Observation of the saled that there was only 2.5 ml after this was brought to the he added another 1.5 ml to		All of the facility TMEs were trained administration refer to attachment #5 In the future, the facility will ensure medications are administrated as prothe physician.	4-29-08 that all of
	Advair discus inha client, however, di appropriate mome the Advair discus. client any instructi TME was not obseensure that Client	e TME squeezed 1 spray of aler into Client #4's mouth. The d not take in a breath at the ent when the nurse squeezed. The TME did not offer the cons during this process. The erved using effective means to #4 received her prescribed ordance with the physician's		All of the facility TMEs were trained administration refer to attachment #5 In the future, the facility will ensure medications are administrated as prothe physician.	4-29-08 that all of
	deep, gurgling cou	ent #4 was observed making a ligh. She gave four coughs time. The client coughed again			

STATEMENT AND PLAN (	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLI	
<del></del>		09G173	B. WIN	1G		04/0	4/2008
NAME OF F	<u> </u>			4	REET ADDRESS, CITY, STATE, ZIP CODE 816 CHESAPEAKE STREET, NW VASHINGTON, DC 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD RE	(X5) COMPLETION DATE
W 369	Observations later deep, bubbly cough At that time, her fact Verification of the north following day, April needed") physician cough syrup, 5 ml kneeded for congest observed receiving when she coughed the RN revealed the administered if she doesn't stop." Whe taken the cough syrup bubbly cough, he reindicate congestion interview with the Disimilar discussion. client clear her lung that Bromatane was suppressant; theref	reral more times at 9:03 AM. Ithat day included several its in succession at 4:19 PM. Ithe turned red as she coughed. Inedication pass on the Ithat day included several its in succession at 4:19 PM. Ithe turned red as she coughed. Inedication pass on the Ithat day included PRN ("as Ithat day included PRN ("as Ithat day included as a sion." Client #4 had not been Ithat day included a day Ithat day interview with Ithat the cough syrup should be Ithat day included a deep, Ithat day included a deep, Ithat would Ithat day included PRN ("as Ithat day included a deep, Ithat day included PRN ("as Ithat day included PRN	W		All of the facility TMEs were trained or administration refer to attachment #5 In the future, the facility will ensure the medications are administrated as pres the physician.	nat all of	ation 4-29-08
	· :		,				
			·				·

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
<u> </u>		09G173	l <del>4</del>			04	/04/2008		
l	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE ESAPEAKE STREET, NW					
STJOHN	1		WASHINGT						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE		
. 1 000	INITIAL COMMENT	rs ·		1 000					
	2008 through April of two residents was a population of four wide disabilities. A focus admission document The findings of this observations at the program, interviews and residential staff.	was conducted from 4, 2008. A random selected from a residuant review of a third ntation also was consurvey were based group home and at a with residents, day f as well as the revies trative records, inclusive.	sample of lent legrees of resident's ducted. on one day program w of						
l 229	3510.5(f) STAFF T	RAINING		1 229	·				
	Each training progra limited to, the follow	am shall include, but ving:	t not be			*	·		
	residents to be sento, behavior manag	related to the GHMR yed including, but no ement, sexuality, nu nmunications, and a	t limited trition,						
	Based on interview GHMRP failed to tra	met as evidenced by and record review, t ain all staff on specia and total communica	he alty areas						
	The findings include	e:							
	the staff in-service with the Residentia Manager)revealed	eginning at 4:00 PM, training records and I Team Leader (aka no evidence that the pport staff on the foll	interview House GHMRP	·. ·		,			
	- physical therapy,				Drag and	Whorker	_		
Health Regul	ation Administration	OUULU C	VTATIVE'S SIGN	Light 1	M-19-12-11-1E	5-1	(X6) DATE		
STATE FOR	M \	<del>,                                    </del>	06	99 6	SWZ11	If contin	nuation sheet 1 of 6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			A. BUILDIN		(X3) DATE SU COMPLE			
		09G173		B. WING_	··· - ··· ·	04/04	4/2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE, ZIP CODE				
ST JOHN				SAPEAKE S TON, DC 2	STREET, NW 0016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
1 229	Continued From pa	ge 1		1 229				
					The Physical Therapy training was con	mpleted	4-24-08	
:	- recreation, and				The recreational inservice was comple	eted on	4-29-08	
	- sexuality.		İ		The Sexuality in service was complete	ed on	4-29-08	
	It should be noted that an incident report dated January 28, 2008 indicated that Resident #1				Refer to attachment # 6 a, b, c,			
received a burn to her right foot after the foot slid under a radiator in the bathroom, while			foot slid		In the future, the facility will ensure t training are completed as scheduled.	hat all of		
	transfering to the commode. The resident relied on staff assistance with transfers to/from her wheelchair to the commode. In addition, review of staff meeting agendas revealed references made regarding Resident #4 receiving assistance and/or support with going on "dates."		n her	·				
			ences					
1 422	3521.3 HABILITAT	ION AND TRAINING		I 422				
	and assistance to r	l provide habilitation, esidents in accordan vidual Habilitation Pla	ce with		··			
	Based on observati review, the facility f medications were a	met as evidenced by ion, interview and recalled to ensure that administered as presidents of the facility.  and #4)	cord					
:	The findings includ	e:						
		cation administration 2, 2008, beginning at s were observed:			All of the facility TMEs were trained o administration refer to attachment #5		ation 4-29-08	
	(TME) squeezed 1 into Resident #1's I resident, however,	trained medication e spray of Flonase nas eft and right nostrils. did not take in a brea nts when the nurse so	sal spray The ath at the		In the future, the facility will ensure t medications are administrated as pre- the physician.			

6SWZ11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLII IDENTIFICATION NU		R/CLIA MBER:	A. BUILDII		(X3) DATE SUI COMPLET		
		09G173		B. WING		04/04	/2008
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE	<u> </u>	
ST JOH	N		4815 CHES WASHINGT		STREET, NW 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
1 422	Continued From pa	ige 2		l <b>42</b> 2		-	
,	resident any instruction TME was not observe that Reside	tle. The TME did not ctions during this pro- rved using effective n nt #1 received her pro- ordance with the phys	cess. The neans to escribed				
	liquid Dilantin into a on top of a file cabi were to receive 4 n As the TME reache to the resident, who table in her wheeld was about to admir Observation of the there was only 2.5	TME poured Resider a medicine cup and prinet. The resident's only of liquid, or 100 mged for the medicine cup was seated at the brain, she indicated the inster the medication. TME's attention, she qual 4 ml.	laced it orders of Dilantin. Up to take oreakfast at she ed that		All the facility TMEs were trained on the administration administration refer to attachment #5  In the future, the facility will ensure the medications are administrated as preside physician.	nat all of	n ⊹29-08
	Advair discus inhal The resident, howe the appropriate mo squeezed the Adva offer the resident a process. The TME effective means to received her presci	TME squeezed 1 spi er into Resident #4's ever, did not take in a ment when the nurse ir discus. The TME on ny instructions during was not observed us ensure that Resident ribed medication in e physician's orders.	mouth. breath at did not this sing t#4		All the facility TMEs were trained on the administration refer to attachment #5 In the future, the facility will ensure the medications are administrated as presented physician.	nat all of	n -29-08
	making a deep, gui coughs repeatedly coughed again at 8 times at 9:03 AM. included several de succession at 4:19 turned red as she of	sident #4 was observingling cough. She ga at that time. The res 3:13 AM and several r Observations later the dep, bubbly coughs in PM. At that time, he coughed. Verification of the following day, A	ive four lident more at day in face		All of the facility TMEs were trained or administration refer to attachment #5  In the future, the facility will ensure the medications are administrated as presented physician.	at all of	ion -29-08

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:		TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		09G173		A. BUILDII B. WING		04/04/2008			
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	ADDRESS, CITY, STATE, ZIP CODE					
ST JOHN	1			CHESAPEAKE STREET, NW HINGTON, DC 20016					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE  Y MUST BE PRECEDED BY  SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE			
1 422		•		1422					
	orders for "Bromata mouth, 4 times dail Resident #4 had no cough syrup the pn At 1:28 AM, intervie the cough syrup sh had "a persistent of When asked if she syrup when she ha RN replied "yes," the At approximately 4 Director of Nursing Coughing would he of congestion. She an expectorant, no	N ("as needed") physiane DX cough syrup, by as needed for congot been observed receivious day when she would be administered ough, that doesn't stop should have taken the dadeep, bubbly counat would indicate could perfect the resident clear affirmed that Bromat a suppressant; then administered in accorders.	5 ml by jestion." eiving coughed. led that if she op." he cough gh, the ngestion. h the ssion. her lungs itane was efore it		All of the facility TMEs were trained of administration refer to attachment #5 In the future, the facility will ensure the medications are administrated as prethe physician.	4-29-08 hat all of			
I 427	Each GHMRP shall	ATION AND TRAINII Il make modifications m at least every six (6	to the	I 427					
	or when the client:  (d) Is being conside objective or objective. This Statute is not Based on observat review, the GHMRI behavioral data wa with intervention president.	ered for training towa ves; or met as evidenced by ion, interview and red P failed to ensure that is collected for Reside ogram(s) established and appropriate by larm review and	rd a new  cord t baseline ent #3, I, as						
-	On April 2, 2008, a	t 7:32 AM, Resident :	#3 waiked						

6SWZ11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4815 CHESAPEAKE STREET, NW  WASHINGTON, DC 20016  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE  COMPLETED  (X3) DATE SURVE  COMPLETED  (X3) DATE SURVE  COMPLETED  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTION SHOULD BE  COMPLETED								
NAME OF PROVIDER OR SUPPLIER  ST JOHN  STREET ADDRESS, CITY, STATE, ZIP CODE  4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/GLIA IMBER:	A. BUILDIN			
ST JOHN  4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		·	09G173				04/0	4/2008
WASHINGTON, DC 20016  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	NAME OF	OF PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
PROPERTY (EACH DESIGNATION OF PROPERTY OF ANY COLUMN	ST JOH!	DHN .						
TAG DECIKATORY OF LOG IDENTIFICATIONS	PRÉFIX	IX (EACH DEFICIENCY	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	OULD BE	(X5) COMPLETE DATE
Out of her bedroom and came through the living room on her way to the dining room. She stopped next to a floor lamp in the living room, leaned forward and placed her nose (briefly) against the lamp shade, before continuing to the dining room. A moment later, she bent over and touched her nose to a bouquet of artificial flowers that were in the center of the table. At approximately 8:15 AM, she repeated this behavior, when she placed her nose briefly against the back of her dining room chair.  During the entrance conference, at 9:10 AM that morning, the Residential Team Leader (RTL, aka House Manager) indicated that the resident had exhibited the nose-ing behavior since she was admitted to the facility in June 2007. The resident would rub her nose on facility walls as well, leaving mucous on the walls. This reportedly had been especially heavy in December 2007, when she was treated for a sinus infection. The behavior, however, had not yet been assessed by	l 427	out of her bedroom room on her way to stopped next to a fileaned forward and against the lamp shadining room. A more touched her nose to that were in the cer approximately 8:15 behavior, when she against the back of During the entrance morning, the Reside House Manager) in exhibited the nose-admitted to the faci would rub her nose leaving mucous on been especially her she was treated for behavior, however, their psychologist was facility to assess the and to provide approximately approximately within On April 4, 2008, but Resident #3's record admitted on June 2 assessed her short Psychological Evaluation of the psychologist record and the	and came through to the dining room. Shoor lamp in the living placed her nose (broade, before continuisment later, she bent to a bouquet of artificinter of the table. At AM, she repeated the placed her nose brid her dining room charter of the table at the residuated that she residuated	ne proom, iefly) ng to the over and ial flowers nis efly ir.  O AM that (RTL, aka dent had he was he resident well, irtedly had of, when he sessed by the to the pehavior ations.  Imple, a hentation admitted months.  I review of e was gist  1, 2007, ng	I 427	Staff did collect data to baseline ind behaviors of concerns for 30 days a by the Psychologist; however, based data collection, there was no sufficindicated the intensity of this behavalso individual #3 was diagnosed with supdating individual #3 baseline for concerns.  In the future, the facility will ensure	s recommend d on the cient data that vior, and vith Sinus. he Psychologi or her behavior	st

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G173		B. WING		04/0	4/2008	
NAME OF F	ROVIDER OR SUPFLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE			
ST JOHN	V		4815 CHE WASHING	SAPEAKE TON, DC 2	STREET, NW 20016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD 8E	(X6) COMPLETE DATE	
1 427	Continued From pa	ge 5		l 427				
	baseline data since	e that staff had collect then or that the psyc lent #3's behavioral r s that ensued.	hologist					
i 484	3522.11 MEDICATI	ONS		1 484				
	medication that is d or has reached the worn, illegible, or m	promptly destroy pre iscontinued by the ple expiration date, or he issing label. met as evidenced by	nysician as a					
	Based on observation failed to ensure that	on and interview, the all prescribed medic ons, were destroyed	GHMRP ations.					
	The findings include	<b>:</b> :						
	On April 4, 2008, at observation of Residute the following:	approximately 4:48 I dent #4's toiletry kit r	PM, evealed		All of the expired topicals were remove	ed .		
		be of Triple Antibiotic September 29, 2007		•	from the toileting kit, and destroyed.  In the future, the facility will ensure the medications including topicals are remo	at all of oved and	4-04-08	
	2. The label on a tu reflected a June 8, 2	be of Lotrisone Crea 2007 expiration date;	m and		destroyed when they reach their expira Refer to I 484 (1) P. 6		1-08-08	
	3. The label of a co indicated that it had	ntainer of Urea 40% expired on January 2	cream 28, 2008.		Refer to I 484 (1) P. 6		1-08-08	
	The Residential Tea at the time, confirme dates had passed.	m Leader, who was ed that the lotions' ex	present piration		Refer to I 484 (1) P. 6		1-08-08	
		•	1				1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
 		09G173		B. WING		04/	04/2008	
NAME OF F	ROVIDER OR SUPPLIER				STATE, ZIP CODE			
ST JOHN	<b>1</b>	İ	WASHING	TON, DC	STREET, NW 20016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL .	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
R-000	INITIAL COMMENT	rs		R 000				
R 125	criminal history of the contract worker for in all jurisdictions wi employee or contract resided within the se	JND CHECK REQUITOUND CHECK Shall distinct the prospective employment of the prospective worker has worker even (7) years prior to the prospect worker has worker the prospect worker has worker the prospect worker the prospect worker the prospect worker the prospect worker the prospect worker the prospect worker the prospect worker the prospect worker the prospect that the prospect worker the prospect worker the prospect worker the prospect that the prospect worker the prospect worke	sclose the byee or 7) years, ective	R 125				
	Based on the review failed to ensure crim disclosed the crimin employee or contract seven (7) years, in a the prospective employee.	met as evidenced by v of records, the GHi innal background che all history of any process worker for the prevall jurisdictions within bloyee or contract working the seven (7) years	MRP ecks spective vious which orker had	·				
	personnel records re House Manager) ha background check ( time she was hired. revealed that at the agency, she was em Fairfax, Virginia. Sh beginning August 25 evidence of a backg jurisdiction (Virginia)	ginning at 4:09 PM, evealed that the RTL d only obtained a pa for Maryland and DC Review of her resurtime that she applied apployed by a nursing he had been employed, 2004. There was incound check that i	. (aka rtial c) at the me d with this home in ed there no luded the		All of the personnel files are cur	rently updated	4-07-08	
	year; however, there	was no evidence th	at the					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

if continuation sheet 1 of 2.

(X6) DATE

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDI		(X3) DATE S COMPL	
		09G173				04/0	4/2008
ST JOHN			4815 CHE WASHING	-	STATE, ZIP CODE STREET, NW 20016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
R 125	Continued From pa facility had obtained check, to include Vi	d an updated backgr	ound	R 125			
	Previously, the May included the following	11, 2007 deficiency ng:	report		All of the personnel files are curre	ently updated	4-07-08
	revealed that the Gi evidence that ensur checks were on file history of all the juri	onnel records on May HMRP failed to proving the criminal backgrous and disclosed a sew sdictions where the fail for the House Manafa.	ide und en year emplovee				
	,						
	<u>:</u>			·			
•							
		·					
	••		·				
ealth Regula	ition Administration	·					